

HFM BOCES EMPLOYEE REPORT OF INJURY FORM

Injured Employee Name and Job Title		Injured Employee's Personal Phone #	Injured Employee- Supervisor's Name
Injured Employee Home Address		Date of Injury	Time of Injury
Last Four Digits of Social Security # XXX - XX - _____	Date of Birth	Location of Injury (Building/School/Facility)	Normal Work Hours
If the employee filling out this form is the injured party? Yes/No If no, please enter your Name and Title of Person Completing this form:			
Where incident occurred (room number, hallway, entrance, etc.):			
How did the injury occur? What were you doing at the time? (include detail of any objects or persons that were involved in the injury and leading up to the injury)			
Nature of injury and part of body affected. Be specific (i.e. right hand, left knee, right index finger, strain, cut, bruise, abrasion, etc.)			
Any other people involved in the incident? Yes/No If yes, whom were the people involved? Please list names and titles of individuals involved (include names, titles and contact numbers, if known) And how did the incident end?			
If the person/persons are unknown, please describe those individuals involved.			
List any witnesses (include names, titles, and contact phone numbers)			
Was medical care provided (enter date & time)?		If yes, name of Physician and/or Hospital:	
Is this related to a previous injury (if yes, provide details of previous injury)?		Are you still being treated for injury (if yes, provide name and address of treating physician)?	
Did you stop work due to injury (if yes, what date)?		Expected date of return to work (if applicable)?	
Signature of Employee Completing this Form:		Date:	
EMAIL ALL INCIDENTS REPORTS WITHIN 24 HOURS OF INJURY TO: Workerscomp@hfmboces.org			
THIS SECTION IS TO BE COMPLETED BY HUMAN RESOURCES:			
<input type="checkbox"/> Reportable Injury/Illness (PESH/OSHA) <input type="checkbox"/> Worker's Compensation (Out of Work)			
<input type="checkbox"/> Non-reportable Injury/Illness <input type="checkbox"/> Workplace Violence <input type="checkbox"/> Near Miss			
Notes:			

Instructions: Employees shall use this form to report **all** work-related injuries, illnesses, or “near miss” events (which could have caused an injury or illness) – *no matter how minor*. The information provided on this form enables the BOCES to learn about what contributed to the incident, as well as identify and correct hazards. This form should be completed by employees, and submitted to the Business Office, **within 24 hours** of injury, illness or near miss. Should a situation arise where an employee is unable to complete this form, please contact your principal or supervisor so that they can gather information from you to file this report on your behalf.

If you have a work-related injury, illness, or near miss, you must follow these steps:

1. Immediately report the injury to your supervisor and go see the school nurse so that you can be checked out.
2. Complete this form in entirety. Print clearly and legibly.
3. Submit this form to the HFM BOCES Business Office, Attention: Carene Christensen, via email at workerscomp@hfmboces.org. A copy of this form should also be submitted to your principal or supervisor. The information collected on this form will be submitted to the Public Employer Risk Management Association, Inc. (PERMA), who serves as the Workers’ Compensation administrator for HFM BOCES.
4. Be sure to provide a doctor’s note for any medical treatment, restricted work, or lost time. Send all doctor’s notes related to the incident being reported to the HFM BOCES Business Office, Attention: Carene Christensen, via email at workerscomp@hfmboces.org.
5. Please be sure to inform the doctor/hospital, at the time of treatment, that this is an on-the-job injury.